STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155207	A. BUILDING _____ B. WING _____	C 12/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HAVEN CARE & REHABILITATION CENTER	1201 DALY DR NEW HAVEN, IN 46774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00083726. Complaint IN00083726 - Substantiated. No deficiencies related to the allegations were cited. Survey Dates: December 27, 28, 29, & 30, 2010 Facility Number: 000114 Provider Number: 155207 AIM Number: 100266640 Survey Team: Christine Fodrea RN, TC Rick Blain RN Sue Brooker RD Sheryl Roth RN (December 27 and 28) Census Bed Type: SNF/NF: 92 Total: 92 Census Payor Type: Medicare: 7 Medicaid: 64 Other: 21 Total: 92 Sample: 19 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review 1/04/11 by Suzanne Williams, RN	F 000	**This Plan of Correction is prepared and executed because it is required by the provisions of the state and federal law and not because New Haven Care and Rehabilitation agrees with the allegations and citations listed on pages 1-09 of this statement of deficiencies. New Haven Care and Rehabilitation maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to constitute substandard quality of care or limit our capability to render adequate care.** **Please accept this plan of correction as our credible allegation of compliance.** RECEIVED JAN 18 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	
F 253 SS=C	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Cai Holcroft | HFH | 1/17/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	Continued From page 1 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure cleanliness of the resident shower room for 1 of 2 shower rooms observed, and failed to ensure 1 of 1 medical storage room observed was clean and free of dust and dirt, the storage container for ice scoops for 1 of 2 ice machines was clean and free of paper and debris and that 1 of 1 popcorn machine was clean. This deficient practice had the potential to affect 92 of 92 residents residing in the facility. Findings include: During the environmental tour with the Maintenance Director, Housekeeping Supervisor and Health Facility Administrator on 12/28/10 at 9:30 a.m., the following was observed: 9:40 a.m. - The shower stall in the North shower room had a small scrap of paper and feces on the floor drain. The Housekeeping Director, at that time, indicated the rooms are cleaned daily. At 10:00 a.m., the Health Facility Administrator, after speaking with staff, indicated there were two showers given that morning but no one was aware of feces being on the floor. 9:45 a.m. - The popcorn machine located in the North hall lounge was dismantled and had a large amount of popcorn kernels in the lower trap with the collection trap removed. Two grease covered	F 253	1) F-253 SS = C; 483.15(h)(2) Housekeeping & Maintenance Services The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? **The housekeeping and activity staff were re-educated on the cleaning schedules related to environment in regards to the shower room, ice scoop container, central supply room, and popcorn machine by the Housekeeping Laundry/ Activities Directors by 01/14/10.** b) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? **No residents residing in the facility were affected at the time of the observation. The center staff cleaned the popcorn**	

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F 253	Continued From page 2 popcorn scoops were laying inside the machine and grease was covering the inside surfaces of the machine. The Housekeeping Supervisor, at that time, indicated the Activities Director uses the machine and had made popcorn the other day. On 12/28/10 at 4:55 p.m., the Housekeeping Director indicated the Activity Director indicated that she made popcorn the other day and the machine was hot and she had to wait to clean it. She further indicated she hadn't gotten around to it today yet. 10:30 a.m. - The overflow storage room for medical supplies, near the kitchen, had a large build up of dirt and dust covering the entire floor surfaces. An open box of unpackaged kerlix rolls were observed sitting on a shelf. The box contained 20 plus rolls of kerlix rolls (dressing) with no covering or lid. 10:45 a.m. - The ice machine scoop container on the South hall had bits of paper and liquid on the bottom of the container with an ice scoop inside. On 12/28/10 at 6;15 p.m., the Facility Corporate Consultant provided undated cleaning schedules and a blank infection control log. The schedule for the cleaning of showers indicated it was to be done daily. The schedule did not list the duties of the Certified Nursing Assistants (CNA) following giving a shower to a resident. Maintenance/Central Supply employee #15 was interviewed on 12/28/10 at 3:10 p.m.. During the interview, she indicated the gauze in the box was non sterile, and she was not sure what nursing was using it for. 3.1-19(f)	F 253	**machine, shower rooms, central supply room, and the ice scoop container upon observation on 12/28/10.** c) What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? **Environmental Director, Activity Director/Designee will conduct rounds 4 times a week times 2 weeks, then bi-weekly times 2 weeks then weekly times 4 months to ensure that the shower rooms, central supply room, the popcorn machine and ice scoop containers are clean. These audits will be reviewed in the monthly Performance Improvement Committee for any further recommendations.**	

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain blood sugars as ordered by the physician for 2 of 5 residents reviewed for obtaining blood sugars in a total sample of 19. (Resident #8, Resident #24). The facility further failed to administer sliding scale insulin coverage per physician order for 1 of 5 residents reviewed for sliding scale coverage in a total sample of 19 (Resident #24). Findings include: 1. Resident #8's record was reviewed on 12/27/2010 at 11:10 a.m. Resident #8's diagnoses included but were not limited to, diabetes, depression and high blood pressure. A current physician's order summary dated for the time period of 11/29/2010 to 12/31/2010 indicated Accuchecks (blood sugar checks) were to be obtained at 6 a.m. daily. The physician's order summary further indicated this order had been initially given on 3/11/2010. A review of the Medication Administration Records and Blood Glucose Tracking Forms for November and December 2010 did not indicate blood sugar checks had been completed on 11/2, 11/7, 11/16, 11/17, 11/20, 11/24, 12/18, 12/19,	F 282	d) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and by what date the systemic changes will be completed? **Environmental Director, Activity Director/Designee will conduct rounds 4 times a week times 2 weeks, then bi-weekly times 2 weeks then weekly times 4 months to ensure that the shower rooms, central supply room, the popcorn machine and ice scoop containers are clean. These audits will be reviewed in the monthly Performance Improvement Committee for any further recommendations.** **By what date will the systemic changes be completed? Date of compliance 1/18/11**	

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F 282	Continued From page 4	F 282		

and 12/24.

A review of the nurse's notes did not indicate the resident had refused to have her blood sugars checked.

In an interview on 12/27/2010 at 12:32 p.m. LPN #1 indicated blood sugar checks were charted on ly on the Medication Administration Record or on the Blood Glucose Tracking Form. She further indicated if the blood sugar checks were not charted, they probably were not done.

In an interview on 12/27/2010 at 12:40 p.m. LPN # 3 indicated there was a log book for blood sugar checks, but it was not a part of the permanent record.

A review of the blood sugar log book revealed no available logs for month of November and did not indicate blood sugar checks were completed on 12/18, 12/19, and 12/24.

In an interview on 12/30/2010 at 12:30 p.m., the Director of Nursing indicated she could find no documentation that the blood sugar checks had been completed.

2 A. Resident #24's record was reviewed on 12/29/2010 at 1:25 p.m. Resident #24's diagnoses included but were not limited to diabetes, depression, and anemia.

A current physician's order summary dated for the time period of 11/29/2010 to 12/31/2010 indicated Accuchecks (blood sugar checks) were to be obtained before each meal and at bedtime daily. The physician's order summary further indicated this order had been initially given on 3/17/2010.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSON/PER CARE PLAN

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

1. The nursing staff were re-educated on the documentation of blood glucose on the medication administration record and following the physician orders for any coverage by the DNS/ADNS by 01/15/11.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

2. Resident's who reside at the facility, and require blood sugar monitoring of their sugar levels have the potential to be affected by the alleged practice. There were no significant medication errors noted at the time of the survey.

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F 282	Continued From page 5	F 282		

A review of the Medication Administration Records and Blood Glucose Tracking Forms for November and December 2010 did not indicate blood sugar checks had been completed on 11/11 at 11 a.m., 11/24 at 6 a.m., and 12/26 at 8 p.m.

In an interview on 12/27/2010 at 12:32 p.m. LPN #1 indicated blood sugar checks were charted on ly on the Medication Administration Record or on the Blood Glucose Tracking Form. She further indicated if the blood sugar checks were not charted, they probably were not done.

In an interview on 12/27/2010 at 12:40 p.m. LPN # 3 indicated there was a log book for blood sugar checks, but it was not a part of the permanent record.

A review of the blood sugar log book revealed no available logs for month of November and did not indicate blood sugar checks were completed on 12/26.

In an interview on 12/30/2010 at 12:30 p.m., the Director of Nursing indicated she could find no documentation that the blood sugar checks had been completed.

2 B. A current physician's order summary dated for the time period of 11/29/2010 to 12/31/2010 indicated Novolin R insulin was to be administered per sliding scale according to blood sugar check results as follows 100-150 should be given 2 units, 151-200 should be given 4 units, 201- 250 should be given 6 units, 251- 300 should be given 8 units before each meal and at bedtime daily. The physician's order summary

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

3. **The Director of Nursing, Unit Managers or designees will audit the Medication Administration record 4 times a week for the next 2 weeks then bi-weekly times 2 weeks then weekly times 4 months to ensure compliance with documentation of blood glucose monitoring and following physician orders for any insulin coverage. The Director of Nursing will review the audits at the next monthly Performance Committee Meeting for any further recommendations.**

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F 282	Continued From page 6 further indicated this order had been initially given on 3/17/2010. A review of the Medication Administration Records and Blood Glucose Tracking Forms for November and December 2010 did not indicate sliding scale coverage had been given as ordered on the following dates and times, 11/11 at 7 a.m., the blood sugar obtained was 122. Two units of insulin coverage should have been given. On 12/9 at 7 a.m., the blood sugar obtained was 109. Two units of insulin coverage should have been given. On 12/17 at 7 a.m., the blood sugar obtained was 117. Two units of insulin coverage should have been given. 12/25 at 8 p.m., the blood sugar obtained was 120. Two units of insulin coverage should have been given. In an interview on 12/27/2010 at 12:32 p.m. LPN #1 indicated insulin coverage was charted on ly on the Medication Administration Record. She further indicated if the insulin coverage was not charted, it probably was not done. In an interview on 12/30/2010 at 12:30 p.m., the Director of Nursing indicated she could find no documentation that the insulin coverage had been administered. In an interview on 12/29/2010 at 1:25 p.m. the Regional Director of Clinical Operations indicated there was no specific policy regarding following physician orders. It was understood that all orders were to be followed.	F 282	How the corrective actions will be monitored to ensure the deficient practice will not recur? **4. The Director of Nursing, Unit Managers or designees will audit the Medication Administration record 4 times a week for the next 2weeks then bi-weekly times 2 weeks then weekly times 4 months to ensure compliance with documentation of blood glucose monitoring and following physician orders for any insulin coverage. The Director of Nursing will review the audits at the next monthly Performance Committee Meeting for any further recommendations.** **By what date will the systemic changes be completed? Date of compliance 1/18/11**	
F 514 SS=D	3.1-35(g)(2) 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		

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F 514	Continued From page 7	F 514		

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to document blood sugar results for 1 of 5 residents reviewed for blood sugar documentation in a sample of 19. (Resident #8)

Findings include:

Resident #8's record was reviewed on 12/27/2010 at 11:10 a.m. Resident #8's diagnoses included, but were not limited to, diabetes, depression and high blood pressure.

A current physician's order summary dated for the time period of 11/29/2010 to 12/31/2010 indicated Accuchecks (blood sugar checks) were to be obtained at 6 a.m. daily. The physician's order summary further indicated this order had been initially given on 3/11/2010.

A review of the Medication Administration Records and Blood Glucose Tracking Forms for December 2010 did not indicate blood sugar

F 514 Records Complete/Accurate/Accessible

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

1. The Nursing Staff were re-educated on the documentation of blood glucose monitoring on the Medication RI # 8 had no negative outcomesAdministration Record, and following physicians orders for any coverage by the DNS/ADNS by 01/15/10.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

2. **Resident's who reside at the facility, and require blood sugar monitoring of their sugar levels have the potential to be affected by the alleged practice. There were no significant medication errors noted at the time of the survey.**

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checks had been completed on 12/2, 12/3, 12/4, 12/5, 12/15, 12/17, 12/22, and 12/23.

A review of the nurse's notes did not indicate the resident had refused to have her blood sugars checked.

In an interview on 12/27/2010 at 12:32 p.m., LPN #1 indicated blood sugar checks were charted only on the Medication Administration Record or on the Blood Glucose Tracking Form.

In an interview on 12/27/2010 at 12:40 p.m., LPN # 3 indicated there was a log book for blood sugar checks, but it was not a part of the permanent record.

A review of the blood sugar log book indicated blood sugar checks were completed on 12/2, 12/3, 12/4, 12/5, 12/15, 12/17, 12/22 and 12/23, but had not been transcribed to the permanent part of the resident record.

On 12/27/2010 at 12:40 p.m. LPN #3 indicated blood sugar checks should have been transcribed from the log book onto the Medication Administration Record.

In an interview on 12/29/2010 at 1:25 p.m., the Regional Director of Clinical Operations indicated the facility did not have a policy for documenting blood sugar checks. It was understood the documentation should be completed on the permanent record.

3.1-50(a)(1)

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

3. The Director of Nursing, Unit Managers or designees will audit the Medication Administration record 4 times a week for the next 4 weeks to ensure compliance with documentation of blood glucose monitoring and following physician orders for any insulin coverage. The Director of Nursing will review the audits at the next monthly Performance Committee Meeting for any further recommendations.

How the corrective actions will be monitored to ensure the deficient practice will not recur?

4. The Director of Nursing, Unit Managers or designees will audit the Medication Administration record 4 times a week for the next 4 weeks to ensure compliance with documentation of blood glucose monitoring and following physician orders for any insulin coverage. The Director of Nursing will review the audits at the next monthly Performance Committee Meeting for any further recommendations.

By what date will the systemic changes be completed? Date of compliance 1/18/11

February 10, 2011

RECEIVED

FEB 1 0 2011

LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

Caring is the Key in Life

Brenda Meredith
Public Health Nurse Supervisor
Division of Long Term Care
2 North Meridian St.
Indianapolis, Indiana 46204

Ms Meredith,

REQUESTED ADDENDUM TO 2567 REQU3ESTING DESK REVIEW

F282 F514

Dear Brenda:

Listed below is the addendum to support the POC for the 2567 for our facility. In question were responses to the above listed tags.

F 282 483.20(k) (ii) SERVICES BY QUALIFIED PERSON/PER CARE PLAN

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

1. **The nursing staff were re-educated on the documentation of blood glucose on the medication administration record and following the physician orders for any documentation by the DNS/ADNS by 01/15/11.**

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

app 2/14/11 BM

2. **Resident's who reside at the facility, and require blood sugar monitoring of their sugar levels have the potential to be affected by the alleged deficient practice. All residents' receiving accuchecks for blood sugar monitoring were reviewed to ensure accuchecks were documented. There was no significant medication errors noted at the time of the survey or during audit of accuchecks for residents' in-house, with 1 out of 2 residents documentation of insulin coverage not documented as given.**

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.

3. **The Director of Nursing, Unit Managers or designees will audit the medication administration record daily times 4 weeks, bi-weekly times 4 weeks, and monthly thereafter times 4 months to ensure compliance with documentation of blood glucose monitoring and following physicians orders for any insulin coverage. The Director of Nursing will review the audits at the next monthly Performance Committee Meeting for any further recommendations if needed.**

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How the corrective actions will be monitored to ensure the deficient practice will not recur.

4. **The Director of Nursing, Unit Managers or designees will audit the medication administration record daily times 4 weeks, bi-weekly times 4 weeks, and monthly thereafter times 4 months to ensure compliance with documentation of blood glucose monitoring, insulin coverage given and following physicians orders for any insulin coverage. The Director of Nursing will review the audits at the next monthly Performance Committee Meeting for any further recommendations if needed.**

Residents' are documented on by exception, and each individual resident is monitored independently by there physician for insulin coverage, with orders independent.

Monitoring will be conducted for a period of no less than Six (6) months on all deficiencies referenced in the 2567 for New Haven Care and Rehabilitation.

Respectfully Submitted:

Kris Schmitt RN DNS

Kris Schmitt R.N./D.N.S

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